Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: PINE CREEK MEDICAL CENTER 9032 HARRY HINES BLVD. DALLAS, TX 75235	MFDR Tracking #: M4-09-8514-01
Respondent Name and Box #: ZURICH AMERICAN INSURANCE CO. REP. BOX #: 19	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "Our office is in receipt of an additional payment in the amount of $220.46, however, the dispute remains unresolved. Health Care provider's position is as follows:

1. According to DWC §134.403. Hospital Facility Fee Guideline – Outpatient. (e) **Regardless of billed amount**, reimbursement shall be (f) The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied. (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent when separate reimbursement for the implantables has not been requested.

2. MAR for CPT code 64475-50 is $887.14 X 150% = $1,330.71.

3. Additional $443.57 is still due to the provider."

Principle Documentation:

1. DWC 60 package
2. Hospital or Medical Bill(s)
3. EOB(s)
4. Medical Reports
5. Total Amount Sought per Updated Table $443.57

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: The Respondent did not submit a response to the request for medical dispute resolution.

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Services in Dispute	Calculation	Amount in Dispute	Amount Due
6/23/08	Hospital Outpatient Services	$957.26 (APC) + $(Outlier Amount) = $957.26 (OPPS) x 200% = $1,914.52 (MAR) - $1,470.94 (Total paid by Respondent) = $443.58	$443.57	$443.57
			Total Due:	$443.57

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule §134.403, titled ***Hospital***

Facility Fee Guideline – Outpatient, effective for medical services provided on or after March 1, 2008, set out the reimbursement guidelines for Hospital outpatient services.

This dispute was filed in the form and manner as prescribed by 28 TAC §133.307 and is eligible for Medical Dispute Resolution under 28 TAC §133.305 (a)(4).

1. The services listed in Part IV of this decision were denied or reduced by the Respondent with the following reason codes:
   Explanation of benefits with the listed date of audit 11/17/08:
   - 96-Non-covered charge(s).
   - W1 — Workers Compensation State Fee Schedule Adjustment.
   - W1-This line was included in the reconsideration of this previously reviewed bill.
   - 181-Payment adjusted because this procedure code was invalid on the date of service.
   - 198-Precertification/authorization exceeded.
   - 198-This line was included in the reconsideration of this previously reviewed bill.
   - BL-This bill is a reconsideration of a previously reviewed bill.
   - BL-To avoid duplicate bill denial, for all recon/adjustments/additional pymnt requests, submit a copy of this EOR or clear notation that a rec.
   - 96-This line was included in the reconsideration of this previously reviewed bill.
   - 181-This line was included in the reconsideration of this previously reviewed bill.

   Explanation of benefits with the listed date of audit 4/1/09:
   - 96-Non-covered charge(s).
   - W1- Workers Compensation State Fee Schedule Adjustment.
   - W1-This line was included in the reconsideration of this previously reviewed bill.
   - 181-Payment adjusted because this procedure code was invalid on the date of service.
   - BL-This bill is a reconsideration of a previously reviewed bill.
   - BL-To avoid duplicate bill denial, for all recon/adjustments/additional pymnt requests, submit a copy of this EOR or clear notation that a rec.
   - 96-This line was included in the reconsideration of this previously reviewed bill.
   - 181-This line was included in the reconsideration of this previously reviewed bill.

2. The Respondent correctly denied reimbursement for, CPT codes 77003 and 99070 based upon "96" because it is not paid separately from procedure.

3. The Respondent incorrectly noted that revenue codes 250, 270, 271, 272, 370 and 710 were invalid. These services or procedures are included in the APC rate, but not paid separately.

4. Rule 134.403 (e) states in pertinent part, "Regardless of billed amount, reimbursement shall be:

   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code 413.011; or

   (2) if no contracted fee schedule exists that complies with Labor Code 413.011, the maximum allowable reimbursement (MAR) amount under subsection (f), including any applicable outlier payment amounts and reimbursement for implantables;…"

5. Pursuant to Rule §134.403(f), "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register*. The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 200 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.

6. Upon review of the documentation submitted by the Requestor and Respondent, the Division finds that:

   (1) No contract exists;

   (2) MAR can be established for these services; and

(3) Separate reimbursement for implantables was *not* requested by the Requestor.

7. Consequently, reimbursement will be calculated in accordance with Rule §134.403 (f)(1)(A) as follows:

APC Value	Outlier Payment	Separate Reimbursement for implantables WAS NOT requested under Rule §134.403	APC + Outlier Payment X 200%	Subtract Amount Paid by Respondent	Results in additional Amount Due to Requestor
$957.26	$0.00	$0.00	$1,914.52	$1,470.94	$443.58, Requestor is seeking $443.57.

8. Based upon the documentation submitted by the parties and in accordance with Texas Labor Code Sec. 413.031 (c), the Division concludes that the Requestor is due additional payment. As a result, the amount ordered is $443.57.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. 413.011(a-d), 413.031 and 413.0311
28 TAC Rule §134.403
28 TAC Rule §133.307
28 TAC Rule §133.305

PART VII: DIVISION DECISION

The Division hereby ORDERS the respondent to remit to the requestor the amount of $443.57 plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature	Medical Fee Dispute Resolution Officer	August 14, 2009 Date

PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.